SECTION VI - FOLLOW-UP DATA

Date of Last Contact

NAACCR Version 9.1 Item 1750, columns 791-798

Enter the date, in MMDDCCYY format, of last contact with the patient. This is not limited to contact between *your* facility and the patient; for example, if your facility's last contact was in March but you know the patient was seen elsewhere in April, then the April date should be filled in.

If the patient is dead, this field records the date of death.

For hospitals without follow-up registries, the date entered in this field is probably your facility's discharge date.

Follow-up registries are requested to enter the Date of Last Contact learned from follow-up efforts. If no follow-up information has been received by the time the case is abstracted, enter the date discharged from the hospital. Do not use the date that information was received in the mail, nor the date information was requested from a patient, physician or other follow-up source.

If a patient has multiple primaries, all abstracts submitted for the patient should contain the same Date of Last Contact.

Never use the code for unknown year (**9999**), and do not leave this field empty. You may use the unknown codes for month and day if necessary.

Vital Status

NAACCR Version 9.1 Item 1760, column 799

Enter the patient's Vital Status as of the date entered in the "Date of Last Contact" field. Remember that if the patient has died, the Date of Last Contact should contain the date of death. Use the most accurate information available. If a patient has multiple primaries, all records should have the same Vital Status. Use the following codes:

Status	Code
dead	**0**
alive	**1**

Place of Death

NAACCR Version 9.1 Item 1940, columns 889-891

If the patient has died, enter the code for the U.S. state, Canadian province, or country where the death occurred. Use the codes for Birthplace (Appendix A) to complete this field. (The Massachusetts code is **005**.)

If you know that the patient is dead, but you don't know where the death occurred, enter **999**.

If the patient is alive as of the Date of Last Contact, enter **997** -- do not leave this field empty.

Comments / Narrative Remarks

NAACCR Version 9.1 field "Text--Remarks", Item 2680, columns 4797-5146

This is a free text field holding up to 350 characters*. It should be used to communicate any details about a case that would help the MCR staff to understand its particulars. Is there anything especially noteworthy about the case? Clear up anything that you know we might have to question. Tell us anything about the case that you think is important for us to know, and that is not recorded elsewhere in the fields that we collect. Avoid a call from the MCR by using this field!

For example, this field may contain:

- overflow text from other Narrative fields;
- the patient's own cancer history (known primaries dating from before and after the case that you're reporting); multiple primaries being reported simultaneously
- verification of an unusual primary site/histology combination;
- verification of an unusual behavior/histology or behavior/stage combination;
- verification of an unusual age/diagnosis combination;
- verification of an unusual gender/first name combination;
- notes about a diagnosis that was uncertain as to primary site or histology;
- notes about any uncertain dates that you have had to estimate;
- details about the patient's address that might be important to the central registry -- such as whether the patient was homeless or was from a foreign country (tell us the country here); if the only address you had for the patient was a *current* rather than at-diagnosis address, please tell us that here.

Please do NOT record sensitive patient information that does not concern the central registry in this field! For example, information on HIV or AIDS status, alcohol or other drug abuse, mental illness, venereal disease and hepatitis do not belong here. If you wish to record such information on your data system, use a field that is not collected by the MCR.

* For the CIMS Satellite system, the field can contain no more than 200 characters.

SECTION VI - CASE STATUS INFORMATION

Date Case Completed

NAACCR Version 9.1 Item 2090, columns 952-959

Record the date that the case was completed and passed all edits that were applied at the hospital level. The date should be recorded in MMDDCCYY format.

For facilities reporting cases to the MCR on paper abstracts or via the CIMS Satellite system, please fill in the date on which you finished abstracting the case.

Date Case Report Exported

NAACCR Version 9.1 Item 2110, columns 968-975

(This field does not apply to facilities reporting cases to the MCR on paper abstracts.)

This field records the date on which the electronic abstract was exported from your data system to a file for transmission to the central registry. As with all dates, it is recorded in MMDDCCYY format. Your system probably fills in this date automatically.

Vendor Name / Version Number

NAACCR Version 9.1 field "Vendor Name", Item 2170, columns 981-990

(This field does not apply to facilities reporting cases to the MCR on paper abstracts.)

This field is used by the MCR to track which vendor and which software version submitted the case. It helps define the source and extent of a problem discovered in data submitted by a software provider.

This field should be filled automatically by your data system. It records the name of the computer services vendor who programmed the system submitting the data. The software version number should be included. This field holds up to 10 alphanumeric characters.

Example: Version 3 of the CanDo Registry System might appear as "Cando V3"

Date Case Report Received

NAACCR Version 9.1 Item 2111, columns 996-1003

This field is not collected from your electronic case records. The MCR records the date on which we receive each data file in our offices.